Washington State
Department of Social and Health Services
Aging and Adult Services Administration

Information and Assistance/Case Management
Program Standards

Revised November 1995

Program Definitions

Information and Assistance/Case Management Program Definition

The Information and Assistance/Case Management (I&A/CM) program is an integrated system of functions designed to locate and identify older persons who need service(s) and link them with the most appropriate resource(s). Program functions may range from the simple provision of information to the provision of comprehensive case management. The I&A/CM program is a key element in implementation of the department's Long-Term Care Policy, which promotes the use of in-home and non-medical residential care as preferred alternatives to nursing home placement for vulnerable adults.

I&A Component Definition

The I&A component of the I&A/CM program is the publicly recognized access point for receiving I&A/CM. Functions of the I&A component include information giving service referral, assistance, client advocacy, and screening to determine whether an older person should be referred to the appropriate agency for a comprehensive assessment. The I&A component is also responsible for I&A/CM program publicity and developing and maintaining a file of community resources which serve older people.

CM Component Definition

The primary function of Case Management is to assist functionally impaired adults at risk of institutionalization in accessing, obtaining, and effectively utilizing the necessary services which will enable them to maintain the highest level of independence in the least restrictive setting.

Activities to achieve this goal include:

- a comprehensive assessment of individual needs;
- development of a detailed plan of services; and
- related activities

Case management activities are consumer centered, with the consumer involved in all phases, whether in an active or consultative mode. Case management is designed to assist the adult in exercising his/her options in community-based care; the services are designed to prevent premature institutionalization. The case manager maintains ongoing contact with the client to enable a prompt response to changes in his/her condition and to

ensure the service plan meets the needs of the person. Monitoring activities include the evaluation of the adult's satisfaction as well as outcome measures based on the service plan. Case management is provided only until the person's situation has stabilized.

Case management functions include comprehensive assessment, service plan development, service plan implementation, service authorization, reassessment, reauthorization, service termination planning, and supportive functions as needed. Supportive functions include client advocacy, assistance, consultation, technical assistance, networking, family support, crisis intervention, and follow-up after termination from case management when necessary.

All functions are provided to each case management client. Supportive functions are provided to case management clients only as needed to maintain them in the most independent setting.

Target Population

I&A Component Target Populations

1. Persons age 60 or over who request AASA-funded in-home assistance, Nursing Facility placement, or other AASA-funded residential services;

OR

2. Persons age 60 or over and/or their representatives who are able to locate and access needed services if provided sufficient information;

OR

3. Persons age 60 or over who do not require case management but need someone to assist them or act on their behalf in order to obtain needed services or benefits;

OR

4. Persons age 60 or over who do not appear to meet AASA criteria in #1, but who appear to be at risk of institutionalization, shall be screened to determine if they should be referred to the case management component for a comprehensive assessment.

Medicaid Administrative Claim for I&A Functions.

The following describes Medicaid administrative activities which may be reimbursable under Title XIX Medicaid Administrative Activities.

When determining whether an activity is eligible for federal match as a Medicaid Administrative Cost, two basic rules apply:

1. Does the activity assist an individual to access a Medicaid service (of any kind)?
2. Is federal match already being received for this same activity (e.g., case management)?

Activities Potentially Matchable

A. Pre-screening — functions that appraise an individual's appropriateness for participation in a given program.

B. Outreach — Functions of I&A staff that inform individuals about programs financed by Medicaid and how to access these programs.

   1. Informing individuals, agencies, potential providers, practitioners and community groups about specific Medicaid programs.
   2. Informing individuals and their caregivers served by the agency about their potential eligibility for Medicaid programs, including their rights and responsibilities.
   3. Designing and carrying out strategies to inform high-risk population groups of Medicaid programs that will benefit them.

C. Facilitating Medicaid Application — Activities that directly assist potentially eligible individuals to apply for Medicaid services.

   1. Collecting information that is needed for eligibility determination such as verification of resources, SSN, etc. (In cases where individuals are referred to HCS for core services, this function will be performed by HCS.)
   2. Assisting individuals in filling out and processing eligibility forms for Medicaid programs.
   3. Gathering information to determine the nature and extent of the individual's need for Medicaid services.

D. Client Assistance to Access Services

   1. Arranging for scheduling or coordinating the delivery of Medicaid services.
   2. Providing follow-up contact to ensure that the individual received the Medicaid service identified in the case plan.
   3. Developing referral resources of Medicaid providers for the individual to use.
   4. Providing or arranging for transportation or translation services that assist a client to access Medicaid services.

E. Interagency Coordination — This function is performed by I&A staff when collaborating with other agencies to improve the cost effectiveness of the Medicaid service delivery system.

   Working with other agencies to identify, promote, and develop needed Medicaid services.

F. General Administration — This can be related to any of the above functions.

1. In-service training;
2. Staff travel;
3. Necessary related paperwork.

All persons served shall be members of the target population.

Case Management Target Populations

Described are the case management target populations served by Home and community (HCS) and Aging Network. Ongoing case management includes Service Plan Implementation, Authorization, Reassessment, Reauthorization, and Service Termination Planning.

A. AASA Home and Community Services (HCS) Target Populations

Staff shall provide case management services to all AASA-funded clients:

1. who are newly admitted to a Nursing Facility;
2. who are current residents of Nursing Facilities;
3. who are newly admitted to, or are current residents in, Adult Family Homes or boarding homes;
4. who require case management after an Adult Protective Services (APS) investigation.

B. Aging Network Target Populations

The Aging Network shall provide case management services to all clients, regardless of age, who are receiving community-based services in their homes funded through Title XIX (i.e., COPES, Medicaid Personal Care) and state-funded chore. Individuals who are not receiving these services but are Categorically Needy Medicaid recipients living in their own homes who:

1. Require services from multiple health/social services providers, and
2. Are unable to obtain the required health/social services for themselves, and
3. Do not have family or friends who are able and willing to provide the necessary assistance, and
4. Have at least minimal need for assistance with one or more Activities of Daily Living

also qualify for targeted case management services.

Priority shall be given to persons returning to their homes after hospitalization.

A. Targeted Case Management (level 1)

A goal of case management (level 1) is to provide appropriate intervention only for the duration needed. Case Management is authorized by using SSPS code 4105 (Community-Based Case Management Services).

Use this code, with proper Reason and Objective codes, when level 1 intervention is necessary. Level 1 clients who receive targeted case management services must meet the target population stated above. Other characteristics are as follows:

- Instability of service plan, i.e., frequent changes of providers, housing problems, changing care needs and/or health status, environmental issues, emotional or psychiatric problems, etc.
- Frequent (at least once per month) contacts with or on behalf of client.

B. Medicaid Administrative Activities (level 2)

The majority of activities performed on behalf of clients in level 2 for Medicaid clients are considered Medicaid Administrative Activities.

Medicaid Administrative Activities are those performed by Case Management staff which assist a client in accessing Medicaid services. Contacts may be infrequent. In terms of the Case Management Standards, those functions would include:

1. Performing CAs on clients to determine service needs.
2. Authorizing MPC or COPES on SSPS.
3. Assisting clients in Medicaid eligibility review process.
4. Assisting clients in locating and hiring individual providers.
5. Arranging and preparing for fair hearings.
6. Necessary travel, collateral contacts, and paperwork.

C. SSPS

When a client needs intensive intervention (e.g., moves from level 2 to level 1), case managers will authorize case management services using the SSPS code 4105. At the point when the client's situation has stabilized, and intensive intervention/case management services are no longer necessary, terminate SSPS code 4105 using the proper termination code.

Subsequent tasks performed on behalf of the client will be considered Medicaid Administrative Activities.

D. Aging Network Optional Target Population

Based on staff resources, the Aging Network may choose whether or not to provide case management services to the target population group listed below. Additional criteria may be imposed to further limit the number of persons in this target population. These criteria must be in writing. When the Area Agency on Aging (AAA) contracts for case management, the criteria shall be approved by the AAA and sent to AASA for informational purposes. When the AAA directly provides case management, the criteria must be approved by AASA.

Adults age 60 or over who reside in the community are assessed as able to remain in a non-residential setting and

1. Require multiple services and/or perform the required activities for themselves; AND
2. Are unable to obtain the required services and/or perform the required activities for themselves; AND
3. Do not have family or friends who are able and willing to provide adequate assistance.

E. Assignment of Ongoing Case Management Responsibility

Home and Community Services staff shall provide ongoing case management to the target population described in Section A. The Aging Network shall provide ongoing case management to the target population in Section B. In unique circumstances, Home and Community Services and Aging Network case management staff may agree to modify the usual assignment of case responsibility. Such negotiations shall be made during the Service Plan Development process.

F. Case Management Intervention

A goal of case management is to provide appropriate services only for the duration needed. Activities shall focus on the placement of clients in the appropriate level of Case Management Intervention. Reassessments shall focus on the level of intervention required as well as need for services. Specific goals to achieve a reduced level of intervention shall be redesigned and the plan shall be documented in the case file. Case managers shall adhere to contacts, as required by AASA-funded programs.

Legal Limitations on Disclosure of Information

Legal limitations exist on a case manager's disclosure of information about his/her client. This is true whether the case manager works for the state directly or for a local agency. The law treats all communication received from the client as confidential, whether verbal or written, including records derived from those communications. Confidentiality for APS clients shall be followed as stated in Chapter 6, "Adult Protective Services," Section IX (WAC 388-320) in Aging and Adult Services Field Manual.

The case manager may disclose those communications to anyone with his/her client's prior, informed consent. Without that prior informed consent, except for disclosures to auditors and researchers in defined circumstances, the case manager may only make disclosures of information for purposes directly connected with the administration of the program under which the client is applying for or receiving benefits. In short, so long as the disclosure is for the purpose of providing service, it would be appropriate.

Disclosure of information to others does not abrogate a client's expectation of privacy protected by the law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. The case manager is responsible for impressing this upon the service providers with whom he/she works.

The fact that disclosure to another service provider has been made does not, in and of itself, permit that provider access to all the records or information the case manager may have. Disclosure beyond what the case manager initially volunteers is at the discretion of the case manager without the written authorization of the client.

In conclusion, the disclosure of information required for a coordinated assessment of a client and for the coordinated delivery and monitoring of services to that client by a case manager and service providers he/she contacts is permitted by law. That group must maintain confidentiality. Disclosure to individuals outside that group is not permissible without consent.

Code of Ethics

Each service provider must have on file written policies containing ethical standards of behavior. Such policies must be distributed to all employees, and each employee must receive training which will enable the employee to apply these policies into practice.

Presently, section 8 of the Basic Contract refers to Conflict of Interest as set forth in:

1. Executive Conflict of Interest Act, Chapter 42, 18 RCW;
2. Misconduct of Public Officers, Chapter 42.20 RCW:
    a) Code of Ethics for Public Officials, Chapter 42.21 RCW;
    b) Code of Ethics for Public Officers and Employees, Chapter 42.22 RCW;
    c) Code of Ethics for Municipal Officers-Contract Interests, Chapter 42.23 RCW.

The purpose of the Code of Ethics policies should be to provide guidelines and clear directions to employees as they provide services to vulnerable, frail individuals.

These policies should, at a minimum, address the following:

1. Acceptance or usage of a client's money, property, i.e., sharing living expenses or purchasing bulk items, accepting gifts;
2. Purchase of client's property, real and otherwise;
3. Selling to client services, property, investments, or anything else of value;
4. Setting parameters of time and relationships; i.e., employee off-time and employees' friends or relatives performing activities or services for clients;
5. Issues regarding the roles of the employee related to protection of the client with regard to financial interests, health care decisions, living arrangements; i.e., when guardianship, power of attorney/or protective payee is indicated and limits on who may be such a fiduciary.

Consequences of breaching ethical conduct should be included also:

Administrative Requirements

Service Delivery Option

1. An AAA may choose to contract with the same service provider for both the I&A and CM components, contract with one service provider for the I&A component and with another for the CM component, directly administer one or both components or ensure that one or both components are provided by an agency that is not under contract but has entered into a formal agreement with the AAA. This formal agreement shall

include a statement that the agency not under contract will comply with the I&A/CM program standards.

2. Even though AAAs have several options in organizing the delivery of I&A/CM, each AAA shall ensure that all I&A/CM functions are part of an integrated system. If an AAA chooses to contract or provide separately for the I&A and CM components, the AAA shall prepare a written plan describing how the separate components will be coordinated.

Multi-Service Providers

If the I&A/CM, I&A, or CM service provider provides other services, a separate I&A/CM, I&A, or CM program unit shall be established.

Interview Space

All I&A and/or CM service providers shall provide a designated space where client interviews and family conferences can be conducted in private.

Service Accessibility

1. All agencies providing I&A and/or CM services shall be able to work with persons who speak a language other than English and with those who have vision or hearing impairments.
2. All agencies providing I&A and/or CM shall understand cultural differences and take them into account when delivering services.

Telephone Service

1. Both the I&A and CM components shall have adequate telephone service to perform the activities for which they are responsible. Information giving, most service referrals, assistance and screening to determine the need for a comprehensive assessment are most commonly and efficiently performed over the telephone
2. There shall be sufficient telephone lines so that I&A and CM staff can call out and people can call in without getting a frequent busy signal.
3. If the I&A or CM component cannot be reached without a charge, a toll-free or collect calling system shall be established.
4. The telephone shall be answered with the same program title as that used in program publicity.
5. If the I&A or CM component does not have 24-hour telephone coverage, the I&A or CM service provider shall:
    a) Develop a formal written agreement with another organization to handle emergency calls after I&A or CM working hours.
    b) Provide training to the staff of this organization so they can effectively deal with older persons and emergencies
6. It is preferable to have all calls dialed to the regular I&A or CM telephone number automatically forwarded to the emergency telephone number after I&A or CM

working hours. If this is not possible, the emergency telephone number(s) shall be listed in publicity about the I&A/CM program.

7. Both the I&A component and the CM component shall be able to contact a case manager during working hours. Case managers who are in the field shall leave a telephone number where they can be contacted or, if this is not possible, check in regularly with the office.

Working Agreements

1. The I&A/CM Program, or both the I&A and CM components if there is not a single service provider, shall identify the primary community resources used by older persons. When deemed necessary and appropriate, working agreements with these resources may be developed. These resources may include Home and Community Services, other AAA service providers, mental health centers, home health agencies, and legal services providers.
2. Working agreements may address at least the following:
   a) How long each party will take to respond to a request for service,.
   b) Release of information procedures.
   c) Referral and follow-up procedures.
   d) How each party will notify the other of program changes and unavailability of service.
   e) Procedures for working out problems between the two parties.
3. To assure clarity and allow for staff turnover, the I&A service provider shall put in writing what has been agreed to above and send a copy of this to the other community resource.
4. Working agreements may be reviewed as needed.

Insurance

All providers of I&A or CM services shall carry insurance in the types and amounts which meet acceptable business and professional standards.

Record Maintenance

1. A record shall be kept on each I&A/CM staff person and volunteer and shall include the following:
   - Name, home address, phone number.
   - Name, address, and phone number of physician.
   - Name, address, and phone number of person(s) to be contacted in case of emergency.
   - Education and experience.
   - Job assignment and salary.
   - Evaluation of performance at least yearly.
   - Dates of employment and termination.

- Record of attendance.

2. Program and client records shall be maintained to provide an information system which assures accountability to clients and the I&A/CM program and funding agencies and also supplies data for community planning efforts. The information system established shall comply with AASA, AAA, and service provider policies and include, but not be limited to, the following:

   - A fact sheet containing personal and demographic information on the client and his/her informal support system.
   - A current electronic and a hard copy of the Comprehensive Assessment (CA), DSHS 14-327(X), and CA Service Plan, DSHS 15-221(X).
   - The electronic and a hard copy of the Interim Reassessment/Termination, DSHS 14-328(X) form completed during service plan reviews.
   - The current copies of Social Services Authorization, DSHS 14-154(X), and Change of Service Authorization, DSHS 14-159.
   - Pertinent correspondence relating specifically to the client.
   - A narrative record of client contacts, including problems encountered and service plan modifications developed in response.
   - Such other documentation as may be necessary to systematic case management and service plan continuity.

Referral for I&A/CM

1. Referrals for I&A and/or CM shall be accepted from any source and may include older persons seeking or already receiving another service through Home and Community Services, Aging Network, or a community agency.
2. The I&A component shall be publicized as an access point to Long-Term Care Services. Service providers shall be instructed, and community agencies shall be encouraged, to refer clients who might need long-term care services to the I&A component for screening, rather than making a direct referral to the CM component. Individuals who contact or are referred to the I&A component shall be screened to determine which, if any, I&A functions are required, and to determine if a referral to Home and Community Services for a CA is appropriate. The I&A component shall use a screening tool which has been approved by AASA.
3. Referrals to the CM component may come directly from a potential client or from another Aging Network service provider or community agency, although this is not encouraged; and all publicity shall emphasize that referrals should be made to the I&A component. In the few cases where a direct referral is made, the potential client will not have been screened; and CM staff shall perform a screen to determine if a referral should be made to Home and Community Services for a CA or to the I&A component for further screening.

4. Persons referred to the I&A/CM program who are in need of Adult Protective Services shall be directly referred to Home and Community Services in accordance with the instructions in the AASA Field Manual, Chapter 6.
5. If requested, the source of a referral to the I&A component shall be notified of the I&A functions that have been, are, or will be provided. This notification shall occur within five working days after the referral is received.
6. Persons age 60 or over who request AASA-funded in-home assistance, Nursing Facility placement, or other AASA-funded residential services shall be referred to the local office of Home and Community Services for a CA.

Case Finding

1. Each I&A/CM program shall develop a system to identify people who do not come into contact with traditional referral sources and inform them of services available.
2. "Gatekeepers" are those individuals in the community who are most likely to come into contact with vulnerable older persons: apartment, hotel and mobile home park managers; postal carriers; gas, electric, and water meter readers; fuel oil dealers; appraisers; police and firemen; grocery store clerks (especially those who deliver groceries); pharmacists; bartenders, hospital emergency room staff; ministers and priests; etc.
3. Each I&A/CM program shall identify and contact "gatekeepers" in its service area and educate and/or train them on the goals of the I&A/CM program, the services it provides, its relationship to other programs for older persons within the area, and how they can play a vital role in the service delivery system by referring the names of vulnerable older persons to the I&A/CM program as they encounter such individuals during the course of their daily activities. Whether they refer to the I&A or CM component shall be determined by the AAA.
4. Once a referral is received from a "gatekeeper," it is the responsibility of the I&A/CM program to follow up and contact the individual referred. It is also the responsibility of the I&A/CM to periodically re-contact each "gatekeeper" to ensure continued cooperation. The AAA shall decide whether the I&A or CM component assumes these responsibilities.

I&A Component Functions

Program Publicity

1. The purpose of program publicity is to inform older persons, persons acting on their behalf, and the general public about the availability of the I&A/CM program and how it can be accessed.
2. The title used in publicizing the I&A/CM program shall include a term describing the population served (Elderly Services, Senior I&A, etc.).
3. The availability of I&A/CM shall be publicized through the mass media (radio, television, newspapers) at least twice a year. If possible, articles describing the program should be publicized in the senior newspaper of the service area at least

twice each year. If possible, the I&A component telephone number(s) should appear in every issue of the local senior newspaper.

4. Brochures and/or posters which include the title used in publicizing the I&A/CM program, location of the I&A office, hours and days when the I&A office is open, and functions of the I&A/CM program shall be distributed throughout the service area.
5. Publicity about the I&A/CM program shall include the telephone number of the I&A component and identify this number as the one to call for help or information. If another telephone number must be used for emergency calls after I&A working hours, this number shall also be publicized.
6. The I&A component telephone number(s) shall be listed in the yellow pages of the telephone book under the "Senior Citizens" heading, and the title used shall be the same as the title used in program publicity.
7. If the I&A/CM, I&A, or CM service provider determines that a significant number of potential I&A or CM clients speak a language other than English, the I&A/CM program shall be publicized and brochures developed in that language.
8. The I&A component shall periodically contact appropriate DSHS providers within its service area to inform them about the availability of I&A/CM.
9. As appropriate, the I&A component shall periodically contact employers, civic groups, professional organizations, etc., to inform them about the availability of I&A/CM.

Information Giving

1. The purpose of information giving is to provide an older person or his/her representative with enough information to enable him/her to locate and obtain needed services without additional assistance from the I&A component. Such information is usually provided over the telephone.
2. If the simple provision of information is not enough to enable the older person or his/her representative to access needed services, I&A staff shall conduct a screen to determine whether the older person needs additional help from I&A and/or should be referred to Home and Community Services for a comprehensive assessment.

I&A/CM Screening

1. The purpose of screening is to determine whether an older person needs service referral assistance and/or client advocacy from the I&A component and/or is a potential case management client who should be referred for a comprehensive assessment.
2. Screening will usually be provided over the telephone, but may be provided in the field, as appropriate.
3. Screening will usually be done by the I&A component, Home and Community Services staff, or a community agency. However, the CM component may sometimes receive a direct referral for case management, and the potential client has not been

screened. The CM component may conduct the screening in these cases or may refer the potential client to the I&A component for screening.

4. Screening for service referral, assistance, and client advocacy is done by determining if the older person needs this type of help from I&A staff in order to obtain appropriate services or benefits.
5. Screening for referral for a comprehensive assessment is done by determining if the older person appears to meet the criteria for the target population which Home and Community Services and the Aging Network are mandated to serve. If the older person agrees to the referral, he/she shall be referred for a comprehensive assessment.
6. Referrals not meeting the criteria for target population groups served by either the Aging Network or Home and Community Services staff shall be referred directly for appropriate services.
7. Adults in need of Adult Protective Services (APS) are an exception to paragraphs 5 and 6 above. These adults shall be referred directly to the APS program for an APS investigation, following instructions in the AASA Field Manual, Chapter 6.
8. If requested, the referral source shall be notified of case disposition following the screening.
9. Screening shall include direct contact over the telephone with the older person being screened. Although third-party information is valuable in developing an overall impression of an individual's level of functioning, direct contact is necessary to confirm the need for and willingness to receive services.
10. Screening and referral for a comprehensive assessment shall be completed within one working day after contact by the client or receipt of a referral. Document, in the case record, reasons why screening is not completed within one working day.
11. Each I&A/CM program shall develop a screening form which shall be approved by AASA and document at least the following in the client's case record: date of referral, referral source, date of screening, whether the person screened was referred for a comprehensive assessment and, if so, the date of referral.

Service Referral

1. The purpose of service referral is to ensure that an older person is successfully referred to needed community resources. This is a function of I&A staff if the older person does not meet the criteria for case management target population groups served by either the Aging Network or Home and Community Services.
2. Activities included under service referral are:
    a) Provide information and support to the older person to enable him/her to self-refer if this is within his/her capability.
    b) Provide information and support to persons in the older person's informal support system to enable them to make the necessary referrals if the older person is unable to self-refer.

c) Contact resources and make referrals for the older person if neither of the above are possible. I&A staff may not make a referral without consent of the older person or his/her representative.

d) Follow-up with the older person and/or his/her representative within ten working days to determine if referrals were successful, whether the referral process was initiated by the older person, informal support system, or staff.

3. Should the original referrals prove unsuccessful, I&A staff shall identify substitute resources and referrals and make another follow-up contact within ten working days.

4. The referral process for different types of clients shall be as follows:

a) Refer adults in need of adult protective services directly to the APS program at Home and Community Services for an APS investigation.

b) Refer adults who request and appear to need AASA-funded in-home assistance, Nursing Facility placement, or other residential services to Home and Community Services for a comprehensive assessment.

c) Refer to appropriate services those adults who do not meet the case management target population criteria but appear to require other services.

d) Refer to appropriate services those adults (under age 60) who do not meet the criteria for a target population group.

e) If requested, notify the referral source of case disposition following the screening.

Assistance

1. The purpose of assistance is to help an older person obtain a needed service or accomplish a necessary task. Assistance is provided only when the older person is unable to obtain the service or perform the task on his/her own and has no family or friends able and willing to act on his/her behalf. Assistance is a function of I&A staff if the older person will not receive CM services.

2. Assistance may be provided over the telephone, in the field or in the I&A office, as appropriate.

3. Assistance may include such activities as completing a form, finding a living situation, making moving arrangements, arranging for transportation and/or escort services, etc.

4. An older person receiving assistance shall be given the I&A component telephone number and encouraged to call back if further problems arise.

Client Advocacy

1. The purpose of client advocacy is to help an older person receive appropriate benefits or services by intervening with agencies or individuals. Client advocacy is provided by I&A staff only when an older person cannot advocate for himself/herself and has no one in his/her informal support system able and willing to advocate on his/her behalf.

2. Client advocacy is usually provided over the telephone but may be provided in the field or I&A office, as appropriate. An example might be assisting a client at a fair hearing.

Community Resource File

1. The purpose of a community resource file is to give I&A, CM, and Home and Community Services staff ready access to accurate and up-to-date information about resources in the community which provide services to older persons.
2. The resource file shall be totally updated at least once a year, and procedures shall be established for responding to interim information changes.
3. As part of developing and maintaining a community resource file, the I&A component may choose to develop resources not otherwise available. Examples are: maintaining a list of people to do yard work, chop wood, perform household chores, or provide live-in attendant care.
4. The contents of the community resource file shall be available to the I&A and CM component as well as to the local Home and Community Services office.
5. It is the responsibility of the I&A component to develop and maintain a community resource file, which includes the following information about each resource:
    a) Legal name, common name and/or acronym; address; telephone number and days and hours when the resource may be contacted. The same information is required for any branch office of the resource.
    b) Services provided by the resource.
    c) Eligibility requirements and application procedures.
    d) Intake procedures.
    e) Cost of the service and/or donation policy.
    f) Geographic areas served.
    g) Known barriers to facility use (if applicable) or problems with accessibility of services (such as a waiting list).
    h) Name of intake worker and administrators (optional).

CM Component Functions

Comprehensive Assessment

1. The purposes of a comprehensive assessment are to:
    a) Identify the client's needs, abilities, resources, and level of care requirements; and
    b) Identify current and potential care contribution by formal or informal supports available to the client; and
    c) Arrive at a recommendation for services that will meet the needs of the client and support him or her in the most independent setting possible.

2. The comprehensive assessments document the clients' functional assets, deficits, and needs in the following areas:
   a) Demographic information and environmental situation.
   b) Physical and mental health status.
   c) Psychological/social/cognitive functioning.
   d) Ability to perform activities of daily living.
   e) Additional needs identified by the client or others.
   f) Formal and informal support available to the client.
   g) Financial status to verify Medicaid eligibility and to utilize FAST TRACK.
3. All clients who request services or are referred for services funded through AASA shall be assessed by Home and Community Services staff.
4. The Electronic Comprehensive Assessment (CA) form (DSHS 14-327[x]) shall be used to perform all comprehensive assessments and shall be transmitted to the state office upon completion of the service plan.
5. A comprehensive assessment completed by Home and Community Services or the Aging Network shall be accepted by the other agency.
6. The comprehensive assessment shall always be performed in person at the person's current place of residence. Collateral contacts may be made in writing, over the telephone, or in person.
7. Upon date of referral, a comprehensive assessment shall be initiated.
   a) By the end of the next working day if a client is in a hospital and is requesting Long-Term Care Services.
   b) Within five (5) working days if the person is in the community and in jeopardy of imminent harm or institutionalization (hospitalization or nursing home placement) except when:
      - A longer or shorter response time is requested by the referral source.
      - A longer or shorter response time is requested by the client.
      - The client is not available for face-to-face contact.
   c) If response time is over five working days, the reason for the delay must be documented in the case file.
   d) "Initiation of the assessment" means face-to-face contact with the client to gather and record on the CA all information which can be obtained from the client.
   e) Initiation of the CA to client sign-off on the service plan shall be accomplished within 30 calendar days and shall include the following activities:

- Complete the CA, including a draft of the service plan.
- Obtain agreement of the proposed service plan from the client or his or her representative.

8. The assessor shall, if requested, report the disposition of the referral to the original referral source within five working days after the CA is completed.

Service Plan Development

The purpose of service plan development is to prepare a comprehensive, written service plan which clearly defines implementation responsibilities. The service plan shall reflect all needs as documented in the CA including, but not limited to: medical and functional care needs, required environmental modifications, and, if necessary, assistance in submitting a Medicaid application to the local CSO. The client and/or his/her representative shall always be involved in the service plan development unless there are very unusual circumstances which shall be documented in the client's case record.

A. Service Plan Development Process

The assessor completing the initial assessment shall be responsible for developing the initial service plan with the client and/or his/her representative(s). Transfer for ongoing case management shall occur when:

- services are authorized, and
- Medicaid eligibility verified, and
- the Medicaid application has been submitted with necessary documentation.

1. Case staffing involving both Aging Network and Home and Community Services staff shall be held when:
   a) the client has been determined to need case management after completion of an Adult Protective Services investigation; and/or
   b) it is deemed necessary by all parties that significant complications in the client situation will result in the client's premature institutionalization.
2. For other case management target population groups, the Area Agency and Home and Community Services shall develop procedures which specify the criteria for deciding who will be involved in service plan development and whether this involvement will be in person or over the telephone.
3. As warranted by client need, one or more of the parties listed below shall participate in the case staffing when held or be contacted for relevant information about the client when there is no case staffing.
   a) DSHS Community Nurse Consultant.
   b) DSHS Quality Assurance Nurse.
   c) HCS Social Worker.
   d) AAA case manager as appropriate.
   e) AAA oversight RN or nurse delegator.

f) Professional staff from state and community agencies.

g) Care providers, including health care providers.

h) Significant others in the client's informal support system.

4. The assessor shall be responsible for coordinating development of the case management service plan. To prepare a proposed service plan for presentation at an interdisciplinary case staffing, the person who performed the assessment shall:

a) List the service options discussed with the client or his/her representative and recommend the most appropriate service plan.

b) Indicate the services preferred by the client or his/her representative.

c) Verify financial status and eligibility and, in the case of "FAST TRACK," submit a Medicaid application with necessary documentation.

d) List formal and informal services which are already in place and will continue as part of the service plan (home health, home-delivered meals, etc.)

e) Describe in detail the problems and unmet needs according to instruction for completing the DSHS 14-327(X).

f) Identify services and activities which address each identified problem or need, according to instructions for completing the DSHS 15-221(X).

g) Describe how the proposed services adequately meet the client's health and safety needs.

Case staffing participants shall:

a) Observe service plan development policies and procedures described in Chapter 4 of the Aging and Adult Services Field Manual.

b) Request more information if the assessment is incomplete or inadequate to make informed decisions.

c) Use their expertise to review the proposed service plan and determine if it is sufficient to maintain the client's health and safety.

d) Revise the proposed plan as necessary.

5. Development of the service plan shall be completed within 30 calendar days of initiation of the CA.

6. If necessary, a temporary service plan appropriate to client health and safety shall be implemented while a longer term plan is under development.

7. Client confidentiality consistent with state law and department policy shall be ensured.

Ongoing case management shall be provided according to the agency's target population. In general, the agency providing ongoing case management shall perform any necessary activities that cannot be performed by the client and/or his/her representative. Examples

are: finding a place to live, help with moving, help with filling out a form, finding a personal care provider, etc.

Such details of case staffing as timing, location, and prior exchange of information may be determined by local agreement.

B. Service Plan Content

1. The written service plan developed in conjunction with the client and/or his/her representative and appropriate professional staff from other agencies shall be documented in the electronic CA Service Plan form, according to instructions.
2. The service plan shall contain all needs documented in the comprehensive assessment and shall include the estimated time lines for implementation of each service.
3. A case management service plan shall describe the services and activities that will be provided to maintain the client in the community or at their highest level of independence. Included in the service plan shall be a description of procedures for handling emergency situations, including procedures for the client, caregiver(s) and case manager, as appropriate.
4. A case management service plan for a client who is in residential care, or who is entering residential care for a short-term placement, describes the services and activities that will be provided to enable the client to move to a non-residential care setting.

C. Service Plan Documentation

The assessor who completes the comprehensive assessment and coordinates service plan development shall write the proposed service plan and deliver it to the designated ongoing case manager.

D. Client Agreement Regarding the Service Plan

The assessor or ongoing case manager shall discuss and develop the proposed service plan with the client and/or his/her representative. The service plan becomes final when the client signs and dates t he department approved form or the client's verbal agreement is obtained and documented on the same form. Instances where the form is not signed by the client should be very rare. When the plan is not signed, the case manager shall document on the form the reason(s) why the client did not sign. The client shall not sign a blank agreement form until the plan has been discussed with and understood by the client.

E. Distribution of the Service Plan

The assessor shall distribute copies of the final service plan to those involved in implementing the plan, the ongoing case manager, and to others, as appropriate.

F. Conflict Resolution

Such conflicts of opinion and professional judgment as may arise during the course of service plan development shall be resolved at the direct service level whenever possible. Should Home and Community Services and Aging Network case management staff be unable to resolve a particular issue through direct negotiation. That issue shall be referred to the respective supervisors and, if necessary, to the respective administrators for a decision

Service Plan Implementation

The purpose of service plan implementation activities is to assure the client receives services as indicated in the service plan and receives CM supportive services as necessary.

A. Service Plan Implementation Activities

1. Counseling — Provide counseling to the client and/or his/her representative to encourage cooperation in implementing the service plan or to resolve problems interfering with the client's functioning. Counseling will be provided at the most appropriate location for the client.
2. Service Authorization — Authorize and re-authorize services included in the service plan, arrange for contracts as appropriate.
3. Referral — Ensure that the client is successfully referred to all resources listed in the service plan.
    a) Provide information and support to the client to enable him/her to self-refer if this is within the client's capability.
    b) Provide information and support to persons in the client's informal support system to enable them to make the necessary referrals if the client is unable to self-refer.
    c) Contact resources and make referrals for the client if neither of the above are possible.
    d) Follow-up with the client and/or his/her representative within ten working days after referral is made. This is to determine if referrals were successful, whether the referral process was initiated by the client, information support system, or staff. Should the original referrals prove unsuccessful, the service plan shall be revised and re-negotiated to identify substitute resources and referrals. The case manager shall consult with those parties involved in the original service plan development regarding any substantial changes in the plan.
4. Case Coordination — Maintain contacts with resources involved in implementing portions of the service plan to ensure coordinated service delivery, share new information, and work out any coordination problems which may arise. Coordinate the submission of the Medicaid financial application and required documentation to the local CSO.

5. CM Supportive Functions — Perform or arrange for the performance of one or more of the following case management supportive functions.
    a) Client Advocacy — Intervene with agencies or persons to help individual clients receive appropriate benefits or services.
    b) Assistance — Help the client obtain a needed service or accomplish a necessary task (i.e., complete a form, find a living situation, move, arrange for transportation and/or escort services).
    c) Consultation — Consult with service providers and professionals to utilize their expertise on the client's behalf.
    d) Networking — Develop a series of linkages between formal and informal support systems for the purpose of creating an effective continuum of care.
    e) Family Support —Help the family or others in the client's informal support systems for the purpose of creating an effective continuum of care, etc.
    f) Crisis Intervention — Provide short-term intervention in an emergency situation to resolve the immediate problem before a long-term service plan can be developed.
6. Case Monitoring — Maintain regular contact with the client to carry out the service plan.

B. Regular Contact with the Client

The agency assigned ongoing case management responsibility shall assist with any necessary service plan activities which cannot be performed by the client, his/her representative, or his/her informal support system. Examples are finding a place to live, help with moving, help with filling out a form, finding a personal care provider, etc.

The ongoing case manager shall maintain and document his/her regular contact with the client to:

1. Ensure that care is provided according to the service plan.
2. Monitor that care continues to meet the client's needs.
3. Ensure that the care provider, the client, or his/her representative understands how to make telephone contact to secure routine assistance.
4. Maintain current information about emergency contacts on behalf of the client.

C. Scheduled Contacts

Contacts on behalf of the client shall be documented in the file. "On behalf of the client" means contact may be with the client, a family member, a provider or any other person involved with implementing the service plan. This contact may be in person or by telephone and shall be determined on the basis of the level of case management which the client needs. A higher level of client need for case management will require more frequent contacts and activities.

D. Transfer of Case Management responsibility

The service plan resulting from the initial comprehensive assessment shall be implemented prior to transferring for ongoing case management. This includes all activities necessary to authorize services. When transfer occurs:

1. Clients transferred to ongoing case management shall be informed and provided with the name and telephone number of the appropriate agency or the case manager, whenever possible.
2. The reassessment schedules shall conform to AASA program requirements.
3. The reassessment schedule shall start over when a non-COPES client transfers to COPES. Program requirements shall be adhered to in this situation.

Reassessment

The purpose of reassessment is to determine whether the service plan is still appropriate or whether there have been changes in the client's functioning or situation which warrant revisions to the service plan. The client shall be seen in person.

A. Reassessment schedule

The reassessment schedule described below shall apply to all AASA-funded case management clients, community or residential. These are minimum requirements.

1. A reassessment shall be performed when a significant change in the client's condition occurs, or when it is required by a specific program.
2. A full reassessment shall be conducted when:
    a) There is a change in the client's condition or situation which is serious enough to warrant completion of the entire CA;
    b) Enough interim reassessments have been completed to make it difficult to use the initial CA and subsequent interim reassessments to get a true picture of the client's condition or situation.

B. Content/Documentation of Reassessment

1. Determine whether there has been a significant change in the client's condition or situation.
2. Use the Electronic Interim Reassessment/Termination. DSHS 14-328(X), to document interview reassessments.
3. Revise the case management service plan to reflect significant changes in the client's condition or situation.
4. Distribute service plan revisions as per instructions for the DSHS 15-221(X).

C. Distribution of Service Plan Revisions/COPES Review Documents.

Service plan revisions shall be sent to all affected agencies and/or individuals as appropriate.

Service Termination Planning

A goal of case management is to provide appropriate services only for the duration needed. Activities should be focused on the discharge of clients from publicly funded services. Once the client's situation and plan have been stabilized and someone identified to serve as a contact, termination of case management services shall be pursued.

A. Residential Care Clients

When a client who has been receiving case management from the Aging Network enters a residential facility, the case manager shall:

1. Contact the assigned HCS case manager prior to admission.
2. Work with HCS case manager to assure that:
    a) admission to a residential facility is the only alternative;
    b) the facility can meet the needs of the client.
    c) the rates considered are consistent with the needs of the client and other rates authorized;
    d) there are not facilities in the area that could better meet the needs of the client;
    e) HCS approves of any necessary flexible rate.
3. Authorize SSPS, and
4. Transfer the case to HCS

B. Termination Procedures

1. Whenever case management is terminated, the reason(s) for termination shall be documented in the client's case records. Enter the date of termination and reason for termination on the Electronic DSHS 13-328(X).
2. When case management is terminated, staff shall notify the client and/or his/her representative and all individuals and agencies continuing to provide services, as appropriate.
3. When a client is terminated from case management, CM staff shall document whether follow-up is required and, if so, indicate the frequency of follow-up contacts.

Case Management System Co-ordination

A. It is recommended that case managers from Home and Community Services and the Aging Network meet to discuss referrals, changes in policies or procedures, common problems, and strategies.

B. Procedures shall be established to communicate the identity of the case manager for each client. Included in the communication network shall be, as appropriate:

1. HCS social workers and/or community nurse consultants.
2. Aging Network case managers
3. Oversight Nurse, as appropriate.

Use and Content of Local Agreements

Will be optional, determined by local need.

Staff Requirements

Staffing Plan

Each service provider shall develop a written staffing plan which:

1. Defines the qualifications for and duties of each staff position.
2. Indicates whether each position is full or part-time.
3. Indicates which positions are filled by paid employees and which are filled by volunteers.
4. Describes the skills needed to fill each position.
5. Includes an organizational chart which shows lines of reporting.

Basic Staff Qualifications

1. All staff shall have demonstrated skills and knowledge commensurate with their job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training.
2. All staff who provide I&A/CM services shall have a general knowledge of:
    a) The aging process and disabilities.
    b) The Aging Network service delivery system.
    c) Services funded by Aging and Adult Services Administration and other service delivery systems in the community.
    d) The purpose of the I&A/C program and the services it provides.
    e) Responsibilities of I&A/CM and Home and Community Services staff.
3. All staff who perform I&A/CM functions shall have basic skills in communication and interviewing.

Telephone Screener Qualifications

All I&A components of the I&A/CM program shall have telephone screeners. The CM component may have separate telephone screening staff or telephone screening may be done by a case manager when a person referred to the CM component has not already been screened. Telephone screening staff may be volunteers, but shall meet the same qualifications as paid employees.

1. Duties

Appropriate duties for telephone screening staff are:

    a) Provide information.
    b) Refer for services.

c) Screen callers to determine if assistance is needed.

d) Provide appropriate assistance over the telephone.

e) Screen callers to determine whether a referral for a comprehensive assessment is appropriate.

f) Record maintenance

2. Education/Experience

a) B.A. in relevant field (social work, gerontology, psychology, counseling and guidance, sociology) and two years of experience providing direct human services. (Preferred.) OR

At least two years of college-level courses in a relevant field and at least four years experience providing direct human services.

b) Experience may be paid or volunteer.

c) Experience providing services to disabled and older people is preferred.

Assistance/Case Aide Staff Qualifications

Some I&A/CM programs may have separate staff who perform assistance functions in the I&A component. Assistance/case aide staff may be paid employees or volunteers.

1. Duties

Appropriate duties for assistance/case aide staff are:

a) Help older persons complete forms and other paperwork.

b) Provide an older person with transportation or escort in an emergency.

c) Provide other assistance which cannot be provided over the telephone.

d) Develop and maintain the community resource file.

e) Develop lists of persons available for yard work, chopping wood, attendant care, household chores, etc.

f) Assist in preparation of publicity.

g) Under direction of the designated case manager, assist in implementation of the service plan.

h) Record maintenance.

2. Education/Experience

a) At least two years of college-level courses in a relevant field and at least two years experience providing direct human services.

b) Experience may be paid or volunteer.

c) Experience providing services to disabled and older people is preferred.

Case Management Staff Qualifications

All CM components of the I&A/CM program shall have case managers. All case managers shall be paid employees. The term "case manager" is reserved for staff who meet the case manager qualifications.

1. Duties

Appropriate duties for CM staff are:

a) Comprehensive assessment and ability to use the electronic version.

b) Service plan development.

c) Service plan implementation.

d) Direct oversight nurse and case aide in reassessment and reauthorization activities, as appropriate.

e) Service plan reassessment, reauthorization of services, and ability to use the DSHS Social Services Payment System (SSPS).

f) Termination planning.

g) Follow-up after termination from case management.

h) Record maintenance.

i) Case management supportive functions (client advocacy, assistance, consultation, networking, family support, crisis intervention).

2. Education/Experience

A. Case managers will meet at least the following minimum education and experience requirements:

1. Master's degree in behavioral or health sciences and one year of paid on-the-job social service experience; OR

2. Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social service experience; OR

3. Bachelor's degree and four years of paid on-the-job social service experience.

4. Qualifications outlined in sections C and D below when it has been demonstrated that applicants cannot be located who meet the education and experience requirements in A. 1, 2, and 3, above and one of the two following conditions exist:

a) Bilingual or bicultural staff are necessary to assure access to limited-English speaking or culturally isolated client populations; OR

b) The client populations are geographically isolated.

B. Individuals functioning as case managers prior to August 28, 1991 who have performed competently as determined by their performance evaluations may be deemed case managers when they meet the following educational requirements:

1. High school diploma or its equivalent and four years of paid on-the-job social service experience prior to August 28, 1991; AND
2. Completion of state-sponsored CORE training.

C. Individuals who serve as case manager trainees in situations which require bilingual or bicultural staff to assure access to limited-English speaking or culturally isolated populations, or where the client populations are geographically isolated, shall meet the following case manager trainee education and experience requirements.

1. High school diploma or its equivalent; AND
2. One year paid on-the-job social service experience.
3. Appropriate bilingual or bicultural skills.

D. The case manager trainee program requires the trainee to:

1. Participate in a three-year, on-the-job case manager training program under direct supervision; AND
2. Participate in a monthly supervisory review of a sample of client assessments and service plans; AND
3. Complete state-sponsored CORE training within the three-year training period; AND
4. Participate in annual performance evaluations conducted by the supervisor; AND
5. Perform competently as a case manager at the end of three years as determined by the supervisor's performance evaluations.

Case Management Case Aide Staff Qualifications

1. Duties

Appropriate duties for case aide staff:

a) Under the direction of the designated case manager, assist in the implementation and monitoring of the service plan;
b) Some reassessment activities;
c) Record maintenance;
d) Some reauthorization activities.

2. At least two years of college-level courses in a relevant field and at least two years experience providing direct human services.

a) Experience may be paid or volunteer.
b) Experience providing services to disabled and older people is preferred.
c) Complete AASA-sponsored training as required.

Supervisory Staff Qualifications

All I&A/CM staff shall have an assigned supervisor. Supervisors shall be paid employees.

The term "supervisor" as used in these standards does not necessarily refer to a person who has hiring and firing authority, monitors attendance, etc. Although this person may also perform the job duties listed in Item 1, this is not required. The person performing the listed job duties might be called a "consulting supervisor," but the AAA must ensure that he/she meets the education/experience requirements listed in Item 2.

1. Duties

Appropriate duties for I&A/CM supervisors are:

   a) Maintain regular contact with staff.
   b) Review case records with staff to determine effectiveness of actions taken.
   c) Provide field training for case managers.
   d) Ensure that staff understand and are able to use the Electronic Comprehensive Assessment, Social Services Payment System (SSPS), and Fair Hearing process.
   e) Provide and arrange for formal staff training.
   f) Provide consultation to staff as needed.
   g) Arrange for appropriate case consultation by other professionals, as needed.
   h) Review a sample of client records for accuracy and completeness at least once every 90 days.
   i) Conduct a formal evaluation of each staff person at least once a year.

2. Education/Experience

   a) B.A. in relevant field (Master's preferred) and two years of experience providing direct human services or two years of supervisory experience.
   b) Experience may be paid or volunteer.
   c) Experience providing services to older people is preferred.

Program Director Qualifications

Each I&A/CM program, or each component if the program is divided among more than one service provider, shall have a program director. The program director shall be a paid employee

1. Duties

   a) Develop and implement program policies, goals, and objectives.
   b) Hire and supervise appropriate staff.
   c) Arrange for volunteer and student assistance and supervision as appropriate.
   d) Manage day-to-day program operation.

e) Develop program operating procedures, personnel policies, job descriptions, and record-maintenance system.

f) Submit reports to Governing Board or parent agency director and to AAA.

g) Develop and maintain linkages with community agencies and organizations that could give support to the program or individual older persons.

h) Educate community agencies and groups and the general public on the goals of the I&A/CM program, the target population, and services provided.

i) Develop program publicity.

j) Establish systems for evaluating program effectiveness.

k) Ensure that a case finding system is developed and maintained by either the I&A or CM component, preferably the CM component.

2. Education/Experience

B.A. in relevant field and two years of administrative experience (one year of supervisory experience may be substituted for one year of administrative experience).

Supervision

There shall be adequate supervision of telephone screeners, assistance workers/case aides, case managers, and case management case aides.

Orientation/Training

Each service provider shall have a process for identifying the training needs of staff, both at the point of initial employment and during the course of employment, and training shall be provided to meet identified needs.

Orientation

All new staff shall receive an orientation which covers the subjects listed below before providing services to disabled and older persons.

1. Introduction to the Aging Network
2. Philosophy of the I&A/CM program, target population, and program functions.
3. Agency policies and procedures.
4. Introduction to the Department of Social and Health Services, Aging and Adult Services Administration: program requirements, funding, and other community resources that serve disabled and older persons.

Initial Training

1. All new staff shall receive on-the-job training which covers the subjects listed below before providing services to disabled and older persons:

   a) Content of working agreements with other agencies.

   b) Protocol for working with other agencies, including how to make referrals.

c) How to use the community resource file.

d) Procedures for handling emergency situations.

e) How to work as part of a team.

f) How to complete required forms.

2. Telephone screeners shall be specifically trained in using the telephone to provide the services for which they are responsible.

3. A staff person who answers the telephone but does not meet the qualifications for a telephone screener shall be trained to:

   a) Know what information he/she can give.

   b) Take the caller's name and telephone number and tell the caller when he/she will be contacted by a telephone screener or case manager.

   c) Know how to handle an emergency by providing the name and telephone number of community resources that provide emergency services, or by contacting a case manager if time allows.

4. The initial training of case managers shall include observing and working with a supervisor or other case manager for a minimum of two weeks to receive specific training in performing all CM functions. This includes making field visits with the supervisor or case manager and learning the geographic orientation of the area he/she will serve.

5. All staff who work directly with clients shall be certified to provide Cardio-Pulmonary Resuscitation (CPR) according to accepted standards. Completion of a certified course in Standard First Aid and Safety is recommended.

Ongoing Training

Completion of the AASA training program (CORE) is mandatory for all supervisors and case managers within three years, subject to available slots. Participants must attend all sessions; a certificate of successful completion shall document participation.

1. Supervisory contacts:
   Each telephone screener, assistance worker/case aide, case manager, and case management case aide shall have adequate supervision to ensure job performance and to review case records.

2. Formal training:
   Formal training may be through college courses, workshops, seminars or conferences, or may be structured training provided by other agency staff or professionals in the community.
   Formal training shall be provided as needed to each staff person listed below:

   a) Telephone screeners
   b) Case managers
   c) Assistance workers/case aides
   d) Supervisors

3. Field training:
   Supervisors shall ensure that case managers and case aides receive adequate field training.

Gatekeeper Training

"Gatekeepers" shall be trained to identify members of the case management target population and make appropriate referrals to the I&A/CM program.